



Humanistic Counseling Center
PO Box 24242
Cleveland, OH 44124
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CONSENT TO EXCHANGE CLIENT INFORMATION

Client Name: _____ **Today's Date:** _____

Date of Birth: _____

I, _____ hereby authorize the Humanistic Counseling Center to exchange information with:

Service Provider: _____

Street Address: _____

City / State / Zip: _____

Telephone/Fax: _____

Email: _____

Information to be released, requested, or exchanged: (Check all that apply or state specific information)

- | | | |
|---|--|--|
| <input type="checkbox"/> Treatment Summary | <input type="checkbox"/> Psychological Testing Reports | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Medication Information | <input type="checkbox"/> Inpatient Information | <input type="checkbox"/> Medical History |
| <input type="checkbox"/> Diagnosis | <input type="checkbox"/> Intake Information | <input type="checkbox"/> Case File Summary |
| Other (Specify) _____ | | |

The information is being exchanged, requested, or released for the purpose of:

(check all that apply or state reason)

- | | | |
|-----------------------|---------------------------------------|------------|
| Continuity of Care | Treatment Planning and Implementation | Evaluation |
| Other (specify) _____ | | |

I understand that all exchanged information will remain confidential. However, I am aware that the Humanistic Counseling Center Counseling Center cannot control the recipient's use of the information. I understand that this signed statement is valid for 365 days from the date of my signature. I also understand that I may withdraw my consent at any time in writing.

Client's Signature / Date

Parent or Guardian's Signature / Date
(if client is a minor)

Provider or Staff Member's Signature / Date